

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041343

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10755

STATE FILE NUMBER

FILED NOV 7 1963

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2731A Gamble Street</b>		d. STREET ADDRESS (If outside, give location) <b>2731A Gamble St.</b>	

3. NAME OF DECEASED (Type or print) <b>Cora (Dailey) Daley</b>			4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>63</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (last birthday) <b>Abt. 74</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Macon, Miss.</b>	
13a. FATHER'S NAME <b>John Henley</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Widowed</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Sinda B. Lewis - 2731A Gamble St.</b>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10-27-63</b>
DUE TO (b) <b>Cardiac Infarction</b>		<b>10-16-63</b>
DUE TO (c) <b>Arteriosclerotic Heart Disease</b>		<b>----</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4200</b>		
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>5:30</b> a.m. <b>A.</b> Month, Day, Year <b>Oct. 19, 1963</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>Durant, Mississippi</b>	
21. I attended the deceased from <b>Oct. 19, 1963</b> to <b>Oct. 27, 1963</b> and last saw her alive on <b>10-27-63</b> Death occurred at <b>5:30 A. M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <b>10-28-63</b>	
22a. SIGNATURE <b>J.C. Shepard, M.D.</b> (Degree or title)		22b. ADDRESS <b>5010 Page Blvd.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Ship</b>	23b. DATE <b>10-31-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Durant, Mississippi</b>	
24. FUNERAL DIRECTOR <b>A. L. Beal Und. Co. 4303 Delmar</b>		25. DATE RECD. BY LOCAL REG. <b>OCT 30 1963</b>	
26. SIGNATURE <b>Earl Smith, M.D.</b>			

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE EMBALMER

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Vera Thompson Wilson*

Licensed Embalmer No.

*4435*

P. O. Address

*4303 P. O. Box*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.